INTERFACILITY TRANSPORT TASK FORCE MINUTES

July 31, 2001
Kaiser Permanente
1800 Harrison, 8th Floor Room 8N
Oakland, California

Attendees: Charles Rath, MD; Pam Griffith, RN; Art Lathrop; Dan Burch; Leonard Inch; Bob Eisenman, PhD; Don Stanley, RN; Dean Cathey; Cliff Larrabee; David Nevins; Daniel Brothman; Edward Ballerini, RN; Judith Brill, MD; Jan Ogar, RN; Judith Yates; Ross Fay; Michael Belman

EMSA Staff: Bonnie Sinz, RN; Richard Watson; Maureen McNeil

Guests: Fred Claridge; Marlene Rivers (Alameda County EMS Agency)

Ad Hoc Group 1 Minutes (refer to attachment)

Attendance

Bob Eisenman
David Nevins
Leonard Inch
Dan Brothman
Fred Claridge (guest)

Additions to the draft discussion paper (attached) will include topics such as:

- Funding
- Dispatch
- Repatriation
- Regulatory Authority
- Levels of transfers (gurney van ? CCT)
- ED panel coverage

Task Force discussion on Group 1 report:

On-call coverage Discussion

- EMTALA is not the cure
- Some areas are chronic (neurosurgeon) while others have intermittent problems (orthopedic)
- High numbers of IFT may be due to panel coverage problems
- Funding may not solve the problem
- Increasing risk to patients
- Rural-limited physician base in population

Ad Hoc Group 1 (continued)

Funding Discussion

- Lack of MediCal reimbursement codes for some specialty care teams utilized on transports; services are folded into hospital day per dium
- A standard approach is needed before funding can be solicited
- IFT should be by the lowest clinically appropriate level of care
- Some counties are payors
- Hospitals have ambulance contracts that dictate IFT
- 9-1-1 destination policies should reduce need for IFT; right patient to right hospital the first time
- Rural – limited available resources are tied up with IFTs out of the area
- Diversion can occur when ED is backed up waiting for transfers to be picked up

Hospital Diversion/Closure

- Diversion may increase the need for IFT as it may prevent the patient from getting to the right hospital from the field
- High impact on 9-1-1 coverage and EMS transportation
- IFT are unit to unit specific requiring physician approval

Ad Hoc Group 2 Minutes (refer to attachment)

Attendance
Dan Burch
Charles Rath
Pam Griffith
Don Stanley
Judith Brill
Jan Ogar
Dean Cathey

Task Force Discussion on Group 2 Report:

Definitions – Goal 4

Specialty Care means special services, including medications and procedures, beyond the state paramedic basic scope of practice, which are provided by an accredited paramedic or other licensed health professional.

Comments: HCFA only recognizes Specialty Care (or CCT w/special teams) as IFT for reimbursement for defined patients.

Interfacility Transfer means the transfer of responsibility for patient care ant the transport of the patient by ground or air ambulance form a licensed health care facility to another licensed health care facility.

Comments: Keep IFT definition broad with transfer and transport as sub-groups; keeps terms within existing statute language allowing for regulations to be revised

Ad Hoc Group 3 Minutes

Attendance:
Ross Fay
Cliff Larrabee
Art Lathrop
Bonnie Sinz

The group decided to address Objective 6.1:

Participant	Sub-group	Sub-group	Oversight
Hospitals			DHS HCFA LEMSA – education and policy re: provider capabilities and patient destination; base hospital operations
Ambulance Providers			CHP – equipment and vehicle LEMSA – ambulance ordinance
	EMT-I		LEMSA – accreditation; review is complaint driven; scope of practice
	EMT-P		LEMSA – policy, utilization, QI; some LEMSAs restrict EMT-P level IFT due to 9-1-1 conflict and/or charge a fee for oversight (Contra Costa, Alameda); scope of practice; base hospital medical direction PRN and QI; provider agency QI EMSA – licensure; scope of practice
	CCT		RN – BRN; Medical Director approved standing orders LEMSA – EMT-I staff for scope of practice; EMT-P for accreditation and scope of practice EMSA – EMT-P licensure; scope of practice Provider Agency – QI and training Note: If hospital adds staff the senior medical staff is in charge
	Specialized Care		Hospital – based with hospital providing standing orders, policy and QI
	Air		LEMSA – policy; ambulance ordinance
		EMT-P	LEMSA – policy, utilization, QI; some LEMSAs restrict EMT-P level IFT due to 9-1-1 conflict and/or charge a fee for oversight (Contra Costa, Alameda); scope of practice; base hospital medical direction PRN and QI; provider agency QI EMSA – licensure; scope of practice
		CCT	RN – BRN; Medical Director approved standing orders LEMSA – EMT-I staff for scope of practice; EMT-P for accreditation and scope of practice EMSA – EMT-P licensure; scope of practice Provider Agency – QI and training Note: If hospital adds staff the senior medical staff is in charge
		Specialized	Hospital – based with hospital providing standing orders,

Ad Hoc Group 3 Minutes (continued)

Participant	Sub-group	Sub-group	Oversight
Local EMS Agency			EMSA – adherence to standards; EMS Plan; Exclusive Operations Areas
Emergency Medical Services Authority			HHS – adherence to statutory roles and responsibilities
Department of Health Services			HHS – adherence to statutory roles and responsibilities
	Licensing and Certification		HHS – adherence to statutory roles and responsibilities
Payers			Not discussed
Health Care Finance Administration			Not discussed
	Ambulance		Not discussed
	Hospital		Not discussed

Oversight needs/suggestions discussed:

- LEMSA have QI oversight process for IFT originating in Emergency Departments regardless of staffing
  - Standards for level of care
  - Stable patient v.s. 9-1-1 v.s. unstable for transfer
  - Coordinate with HCFA re: violations
  - Discovery protection

- EMT-I Providers:
  - Documentation requirements for PCR
  - QI Program
    - May be LEMSA responsibility or delegated to provider agency if able to handle it.

Task Force discussion on Group 3 report:

- Oversight varies from county to county
- Consider statewide standards to by implemented locally to avoid fragmentation

Approval of Minutes

Review of documents related to IFT provided in document folder

A table of contents was distributed for the document folder. The ambulance ordinances were reviewed and one document was created showing references to IFT from each ordinance. Complete ordinances may be purged from the folder. Electronic copies of ordinances are on file with Bonnie.

Next Meeting Date/Location

Discussion: The Ad Hoc Groups will continue to work on their goals and objectives in separate meetings and/or conference calls.

The Ad Hoc Group Leads will meet on August 23, 2001 at 10:00 a.m. at EMSA to discuss the progress of the Task Force and review goals and objectives for possible adjustment.

Action items: The next meeting is scheduled for **October 30th in Ontario or LA area**. The Ad Hoc Groups will meet from 10-12 noon with the Task Force meeting from 12-3 p.m. Each chairperson will coordinate Ad Hoc group meetings.

California EMS Authority
Interfacility Transports
Discussion Paper

For the Ad Hoc Committee #1 on the Scope of the Issue
Bob Eisenman, Ph.D.

April, 2001

Revised June 1, 2001,
July 25, 2001

Background

Interfacility transports --- i.e. the movement of a patient between one medical facility[1] and another by ambulance --- has become a routine and integral part of medical care practice.

Although no accurate numbers exist, it is estimated that there could be between 250,000 to 400,000 scheduled interfacility transports occurring in California a year. There are also a relatively small number of emergency (non-scheduled) calls to 911 to move a patient from one medical facility to another. And as medical care practice trends continue, the number of interfacility transports is likely to increase in the future.

Yet interfacility transports are but one part of a comprehensive EMS system. Often the same ambulance resources are involved in both 911-related (scene to hospital) and interfacility transports. Currently practices and regulations, including allowable scope of practice, required medical coordination, staffing and vehicle requirements and inter-county rules, vary by local EMS Agency. Given the magnitude and medical value of interfacility transports as well as the importance of maintaining the integrity of the EMS 911 system, it is important to assure that both are able to continue to function adequately and appropriately throughout California.

Types of Interfacility Transports

Currently Interfacility Transports are being utilized to move patients between medical facilities for a number of reasons --- but typically in order to achieve a higher level of care; to move patients between medical facilities (lateral transfers) and along the institutionalized continuum of care. Examples include[2]:

I. Transports for Higher Level of Care:

A. From a hospital ED or in-patient setting to a specialty hospital or center of excellence for special procedures/treatment (e.g. cardiac catheterization, trauma center care, pediatric intensive care, neuro-surgery)

B. From a sub-acute medical facility to a hospital (ED or direct admit) for medical evaluation, tests and/or treatment (e.g. from a SNF to hospital)

C. Urgent transport from a doctor's (medical) office to a hospital for emergency evaluation and/or treatment beyond the scope or capabilities of the medical office

A. From a non-plan hospital ED to a plan hospital ED, once evaluation and stabilization has occurred (post-stabilization) and with the agreement of the treating physician (e.g. transfer to the hospital with which the patient's insurance has a contract)

B. From a non-plan hospital post admission to a plan hospital for continuing and follow-up care.

III. Transports along the Continuum of Care

A. From hospital to sub-acute medical facility for continuing care (e.g. from hospital to SNF, Rehabilitation Center)

Status of Interfacility Transports and Potential Issues

For the most part, interfacility transports appear to be working well. However there are a number of areas of potential concern or issues that if addressed, could improve the movement of patients between medical facilities and the operation of the EMS System as a whole. Areas for consideration include:

1. Develop methods to assure that interfacility transports do not detract from the resources or the ability of the 911-transport system to function appropriately.

2. Increase the use of paramedic interfacility transports, if the local EMS transport system can support the increase without a negative impact on 9-1-1 transport services. Some counties allow paramedic interfacility transports, others do not. Some critical care transports require the skills of a nurse, physician or other specially trained teams. However it has been clearly demonstrated that many interfacility transports can be safely and effectively performed within the scope of practice of paramedics. Given a shortage of nurses to perform Critical Care Transports (CCT), it makes sense to allow paramedics to perform ALS interfacility transports (within their scope of practice) in all counties in California.

3. Improve the ability to move patients across county lines. Some counties restrict the movement of ambulances within their county boundaries. However the most appropriate medical care facility may be located in another county. Thus the movement of ambulances and patients between counties should be allowed when medically appropriate.

4. Improve the ability of medical offices and other medical facilities to obtain an interfacility transport ambulance in 30 minutes or less (urgent) without requiring First –in Responders, when medically appropriate.

5. Seek ways to increase the availability of nurses and CCT transports.

6. Increase the ability to take patients from the field/scene to the hospital of their choice, when medically appropriate. Having such destination of preference protocols in place would decrease the need for and number of interfacility transports.

7. Strengthen requirements for hospitals to contact the patient's plan hospital post-stabilization, in order to assure quality and continuing care.

8. Clarify what, if any regulations are necessary (for example scope of practice, vehicle requirements, ability to cross county lines, etc) and whether such regulations should be at the state or local EMS agency level.

Inter-facility Transfer Task Force
Ad hoc Group 2

July 10, 2001

Summary of May 30, 20001 Conference Call:

During our first conference call we agreed to tackle as our first order of business — Goal 4: establishing standard definitions for call types, levels of service and facilities.

We came to agreement on levels of service fairly easily by using the current definitions found in Health and Safety Code and by creating a definition for specialty care as: a transfer requiring the skills of either (1) a paramedic with expanded scope of practice or (2) an individual with a different or higher license, i.e RT, MD, etc.

We had a much harder time to reaching agreement on the definitions for Call Type. Dan B. proposed using the definitions established by the State Data Committee in 1991. Concerns were expressed from our group that the Data Committee's approach of basing their definitions on location (i.e. Inter-facility transfer from acute care hospital to acute care hospital) did not adequately reflect the needs of patients. After much discussion Dan B. volunteered to work on developing a new approach for defining call types which better reflects the needs of patients.

Discussion

Below is our proposed list of definitions for Level of Service and a new draft list of definitions for Call Type. During our next conference call we need to reach agreement on the Call Type list and begin the work of drafting the actual definitions for each item. Included for review are written definitions for level of service found in H&S Code.

Levels of Service

Advanced Life Support (Paramedic)
Limited Advanced Life Support (EMT II)
Basic Life Support (EMT)
Specialty Care (Paramedic with expanded scope, RN, PA, M.D., etc)

Call Types

Scene Call (not a transfer)

Transfer for higher level of care
Transfer for equal level care

H&S Code 1797.92 **“Limited Advanced Life Support”** means special service designed to provide prehospital emergency medical care limited to techniques an procedures that exceed basic life support but are less than advanced life support and are those procedures specified pursuant to Section 1797.171.

H&S Code 1797.60 **“Basic Life Support”** means emergency first aid and cardiopulmonary resuscitation procedures which, at a minimum, include recognizing respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim may be transported or until advanced life support is available.